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INTERIM PROJECT

Patient Safety Incentives

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Executive Summary

Since the National Institute of Medicine (IOM) released *To Err is Human: Building a Safety Health System*[1] in 1999, the nation has been trying to make the institution of medicine safer. The IOM report concluded that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors.

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivery of care and not on blaming individuals.

Incentives are one of the techniques recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to create systems change. Re-aligning the financial incentives at the heart of our current health care system to focus on quality of care, safety, and outcomes is long over due. Currently, provider reimbursement depends less on the quality of care and resulting health outcomes, and more on the intensity and frequency of services delivered.

In health care, the benchmark for incentives is "pay for performance" (P4P) programs. In pay for performance programs bonuses are paid to participants (physicians, physician groups, health plans, or hospitals) on the basis of specific goals in quality or efficiency.[2] Proponents of P4P programs say that incentives bring about a more collective and holistic approach to patient safety reform.

Pay for performance (P4P) programs may take many forms. Many involve some type of tiered rating system for providers based on quality standards or the use of certain practices. For instance, health care providers may be ranked as an A, B, or C provider. Depending on the design of the incentive system, providers may be reimbursed at a higher rate based on ranking, or consumers may be prompted to utilize higher ranked providers by offering lower co-payments based on rank.

P4P goals or standards may be either clinical or nonclinical. Clinical goals usually measure the processes of care, such as the use of antibiotics or beta-blockers, and short or long term outcomes, such as hypertension, mortality, or quality of life. Nonclinical goals include rating a provider's use of information technology such as use of electronic medical records and e-prescribing.

Although health plan and hospital P4P programs have demonstrated positive results in improving the quality of health care, many warn against viewing P4P initiatives as a cure-all. The design of incentives is critical in determining whether programs succeed. The primary concerns or criticisms of P4P programs include: problems with standardization and transparency of quality measures, problems with quality based measures, incentives for cost-savings that may motivate practitioners to limit services, and the burden of data collection.

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[1] Institute of Medicine, To Err is Human: Building a Safer Health System, Institute of Medicine, (Washington, D.C.: National Academy Press 1999).

[2] Henley, E. A., "Pay-for-performance: What can you expect*?,*" The Journal of Family Practice 54, No 7. (July, 2005): 609-612.

Great care is required so that incentives do not punish providers for factors beyond their control, or inspire them to turn away clients based on demographic characteristics. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Institute of Medicine (IOM), American Medical Association (AMA), and many other national organizations are emphasizing that P4P programs must be designed well to work.

Florida is taking the lead on creating a culture of patient safety. The Legislature established the Florida Patient Safety Corporation (FPSC) in 2004. It does not regulate health care providers. The FPSC is intended to serve as a learning organization, assist health care providers to improve the quality and safety of health care, reduce harm to patients, and work with a consortium of patient safety centers and other safety programs within the state. Two key tasks are creation of a near-miss-reporting system and development of "incentives to encourage patient safety and the efficiency and quality of care."

Staff Recommends

Incentives are going to continue to permeate the health care market. It is likely that over time the health care industry will develop more uniform P4P standards with transparent quality indicators. If this does not develop it may become necessary for the Florida legislature to provide regulatory standards for P4P programs.

The legislature should amend the Florida Patient Safety Corporation (FPSC) enabling legislation to remove barriers to productivity within the corporation. The advisory committee structure should be streamlined to allow the board more freedom to appoint members. Further, the long list of the duties assigned to the board should be limited to those duties that are not already the responsibility of other state organizations (e.g., electronic medical records).

Why focus on Patient Safety?

Spotlight Patient Safety: The Institute of Medicine, *To Err is Human* Report

Since the National Institute of Medicine (IOM) released *To Err is Human: Building a Safety Health System*[3] in 1999, the nation has been trying to make the institution of medicine safer. The IOM report concluded that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Medical errors result in more deaths than breast cancer, AIDS, or car accidents. Further, the report concluded that 1 in 25 hospital patients are injured by medical errors. These errors come at a large cost to society. IOM estimates that medical errors cost approximately $37.6 billion each year and that about $17 to $29 billion of the costs are associated with preventable errors.[4]

The IOM report in 1999 brought patient safety into the political spotlight. The federal government, provider organizations, purchasers, and consumers are all focused on the issue. The states, with their responsibility to protect public health and safety, addressed patient safety in a number of ways. The National Academy for State Health Policy (NASHP) reports that initially States concentrated on the idea of mandatory adverse incident reporting. More recently, states have been moving towards a systems approach to patient safety. States recognize that in order to improve the safety of the health care system, they must collaborate with providers, consumers, and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve desired outcomes.[5]

What is an Error?

Examples of medical errors include: a patient inadvertently given the wrong medication; a clinician misreading the results of a test; and a person with ambiguous symptoms (shortness of breath, abdominal pain, and dizziness) whose heart attack is not diagnosed by emergency room staff.

Errors depend on two kinds of failures: either the correct action does not proceed as intended, or the original intended action is not correct. Errors can happen in all stages in the process of care, from diagnosis, to treatment and preventive care.

Errors that result in injury are sometimes called preventable adverse events. The patient who receives an antibiotic to which he or she is known to be allergic, goes into anaphylactic shock, and dies, represents a preventable adverse event. [6]

Not all errors result in harm. Studies suggest that there are approximately 100-300 near misses for every adverse event resulting in patient harm. Often predisposing unsafe conditions exist for each near miss.[7]

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[3] Institute of Medicine, To Err is Human: Building a Safer Health System, Institute of Medicine, (Washington, D.C.: National Academy Press 1999).
[4] Berntsen, K.J., "How Far Has Healthcare Come since, To Err is Human?" Journal of Nurse Care Quality 19 (2004): 5-7.
[5] Rosenthal, J. & Booth, M., "The Flood Tide Forum – State Patient Safety Centers: A new approach to promote patient safety," National Institute on State Health Policy (2004).
[6] AHRQ Fact Sheet, 00-PO37, (2000).
[7] Florida Patient Safety Corporation, Progress Report, December 1, 2005.

The IOM report defines:

- **Medical error** as the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim.
- **Adverse Event** as an injury caused by medical management, rather than by the underlying disease or condition of the patient.
- **Near Miss** as any potentially harmful event that could have had an adverse result; but, through chance or intervention, harm was prevented.

Where Errors Occur

Errors occur not only in hospitals but in other health care settings, such as physicians' offices, nursing homes, pharmacies, urgent care centers, and care delivered in the home. However, there is very little data available on errors that occur outside of the hospital setting. In a recent investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in Massachusetts.[8]

Public Awareness of Medical Errors is Increasing

According to the federal Agency for Health Care Research and Quality (AHRQ), public awareness of medical errors has been growing. A national poll conducted by the National Patient Safety Foundation found:

- Forty-two percent of respondents had been affected by a medical error, either personally or through a friend or relative.
- Thirty-two percent of the respondents indicated that the error had a permanent negative effect on the patient's health.

Another survey conducted by the American Society of Health-System Pharmacists, found that Americans are "very concerned" about:

- Being given the wrong medication (61 percent).
- Being given two or more medicines that interact in a negative way (58 percent).
- Complications from a medical procedure (56 percent).[9]

A Systems Problem: Most Medical Errors Preventable

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivery of care and not to blame individuals. Health care professionals are human and, consequently, they make mistakes. But research has shown that system improvements can substantially reduce the error rates and improve the quality of health care.

[8] AHRQ, Fact Sheet, 00-PO37, (2000).
[9] AHRQ Fact Sheet, 00-PO37, (2000).

Studies by the federal Agency for Health Care Research and Quality report the following:

- A 1999 study indicated that including a pharmacist on medical rounds reduced the errors related to medication ordering by 66 percent, from 10.4 per 1,000 patient days to 3.5 per 1,000 patient days.
- The specialty of anesthesia has reduced its error rate by nearly sevenfold, from 25 to 50 errors per million down to 5.4 errors per million by using standardized guidelines, protocols, and standardized equipment.

The Florida Patient Safety Corporation

The Florida Patient Safety Corporation (FPSC) was created as part of the medical malpractice legislation passed after many special sessions in 2002 and was established by the Legislature in 2004. HB 1629 created the Corporation, under s. 381.0271, F.S.

The FPSC does not regulate health care providers in the state. The FPSC is intended to serve as a learning organization, assist health care providers to improve the quality and safety of health care, reduce harm to patients, and work with a consortium of patient safety centers and other patient safety programs within the state.

Only a handful of states have taken the initiative to establish patient safety organizations. Florida has the most comprehensive patient safety mandate. The legislature mandated a long list of important tasks for the FPSC. House Health Care Regulation Committee staff has monitored the development of the FPSC by attending Board meetings, participating in conference calls, and attending select advisory meetings.

As demonstrated in their yearly Progress Report published December 1, 2005, the FPSC is moving ahead on nearly all of its mandates. One of the key duties the FPSC is charged with is creating a medical error, near miss reporting system. Near miss reporting is essential to patient safety because if researchers can understand how near errors were averted they can prevent future errors. Part of medical error prevention involves looking into medical errors and “near misses” to find the root cause of the errors. The near miss data reporting system is being developed in coordination with the University of Miami/JMH Center for Patient Safety, Marsh/STARS, and CRG Medical. The near miss reporting system will have the following characteristics:

- Reporting will be voluntary, anonymous and independent of mandatory reporting systems used for regulatory purposes;
- Reports of near miss data will be published regularly;
- Special alerts will be published regarding newly identified significant risks;
- Aggregated data will be made publicly available; and
- The FPSC will report the performance and result of the near miss project in its annual report.

The FPSC expects to go live with the near miss reporting system in March 2006.
As part of their legislative mandate the FPSC is charged with developing “incentives to encourage patient safety and the efficiency and quality of care.” The Health Care Consumer Advisory Committee is responsible for this task.

The FPSC has yet to develop incentives to encourage patient safety and efficiency. Although the FPSC has accomplished a lot in a short time, there are some barriers that are limiting the productivity of the Board.

As noted in the FSPC yearly Progress Report, the advisory committee structure presents challenges for the Florida Patient Safety Corporation. The enabling legislation requires the Corporation to establish 6 advisory committees. Some of these committees have prescribed membership; which creates problems for the Corporation when the prescribed members are reluctant to serve on the committee. Additionally, some of the duties of the advisory committees are duplicative of other patient safety efforts in the state. Most significantly, the technology advisory committee is charged with implementing new technologies, including electronic medical records. The Agency for Health Care Administration (AHCA) has already taken the lead on this issue. Time spent by the Corporation is more efficient in areas where other state entities have not taken the lead, such as development of a near-miss reporting system.

The Case for Patient Safety Incentives

There is widespread agreement that the health care system is broken. Costs are rising and there are deficiencies in quality of care and reliability of care. Incentives are one of the techniques recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to create systems change. Financial incentives are one of the most powerful tools for bringing about behavioral change.[10] Re-aligning the financial incentives at the heart of our current health care system to focus on quality of care, safety, and outcomes is long over due.

Currently, provider reimbursement depends less on the quality of care and resulting health outcomes, and more on the intensity and frequency of services delivered. Florida Statutes provide for incentives as, “a mechanism for recognizing the achievement of performance standards or for motivating performance that exceeds performance standards (s. 216.011, F.S.).

Ideally, realignment of incentives can benefit all stakeholders. Payers, including employers and health plans, can benefit from reduced direct costs due to improved care and outcomes. Employers also can benefit from indirect cost reductions due to increased on-the-job productivity and reduced absenteeism through workers receiving better care. Physicians and hospitals can gain financial rewards and the benefits of increased visibility and recognition for performance excellence and potentially reduce malpractice claims. Finally, consumers can gain from greater choice and access to higher quality of care.[11]

The most popular incentive programs offer financial rewards to increase quality, manage costs, increase patient satisfaction, or invest in and implement technology. Although most incentives are monetary, programs may utilize a combination of financial and non-financial rewards.

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[10] “Principles for the Construct of Pay-For-Performance Programs,” Joint Commission on Accreditation of Healthcare Organizations (2005) Online at: [www.jcaho.org].

[11] Conklin, J., & Weiss, A., “Pay-for-performance: Assembling the building blocks of a sustainable program,” Thomson Medstat, Online at: [www.medstat.com].

Pay for Performance Incentive Programs

In health care, the benchmark for incentives is "pay for performance" (P4P) programs. In pay for performance programs bonuses are paid to participants (physicians, physician groups, health plans, or hospitals) on the basis of progress and/or attainment of specific goals in quality or efficiency.[12] Proponents of P4P programs say that incentives bring about a more collective and holistic approach to patient safety reform.

Pay for performance (P4P) programs are growing in popularity and prevalence at all levels of health care. Programs are instituted by small practices, private consumer organizations, health and managed care plans, and massive federal programs. The programs may include individual physicians, groups of doctors, or hospitals. A study conducted by Med-Vantage in 2004 identified 84 programs – covering 39 million beneficiaries – that had P4P characteristics.

Some estimate that if every non-rural hospital in the country were to implement a P4P plan it could save 65,000 lives, prevent over 900,000 serious medical errors, and save the US health care system about $9.7 billion annually.[13] Others suggest that incentives offer an alternative to the "blame game" of malpractice reform. Rather than putting physicians on the defensive, incentive programs are designed to empower providers with options to increase the quality of care.

Adherence to clinical guidelines and achievement of optimal health outcomes can also translate to dollar savings. The table below presents the business case that can be made at each stakeholder level for participating in pay-for-performance programs.[14]

[12] Henley, E. A., "Pay-for-performance: What can you expect?," The Journal of Family Practice 54, No 7. (July, 2005): 609-612.
[13] "Leapfrog Offers Consumers Expanded Quality and Safety Information," The Journal of Oncology Management, (May/June 2004): 31-32.
[14] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, (2004) Online at: [www.medstat.com].

Table 1: The Business Case for Participating in P4P Programs

Stakeholder	P4P "investment"	Return on Investment
Consumers	• Self-care management • Switch to "excellent" providers	• Increased patient safety • Improved health & productivity • Financial incentives (employer and plan option)
Employers	• P4P program operations • P4P physician rewards • Employee incentives for self-care and switch to excellent providers	• Employee health & productivity • Healthcare cost savings • Employee retention
Health Plans	• P4P operations • P4P physician rewards • Member incentives for self-care and switch to excellent providers	• Reduced health & productivity • Healthcare cost savings • Employee retention
Providers	• Data collection & submission • Practice re-engineering	• Performance rewards • Reputation for excellence • Increased patient volume • Improved patient safety

* Thomson Medstat, 2005

In concept, incentives are a way to encourage the healthcare industry to move towards stronger patient safety standards and a better system of care without imposing extra state or federal regulations. In practice there are obstacles to the design and implementation of such programs. Those who oppose P4P programs usually do so because of flaws in their incentive structure and design, and not because of an underlying lack of belief that incentives could lead to positive change.

Typical Pay for Performance Measures and Incentive Types

Pay for performance (P4P) programs may take many forms. P4P programs pay providers at rates based on their achievement of certain goals. Programs differ on two main aspects: performance measures, and incentive types. Many involve some type of tiered rating system for providers based on quality standards or the use of certain practices. For instance, health care providers may be ranked as an A, B, or C provider. Depending on the design of the incentive system, providers may be reimbursed at a higher rate based on ranking, or consumers may be prompted to utilize higher ranked providers by offering lower co-payments based on rank.

P4P goals or standards may be either clinical or nonclinical. Clinical goals usually measure the processes of care, such as the use of antibiotics or beta-blockers, and short or long term outcomes, such as hypertension, mortality, or quality of life. Nonclinical goals include rating a provider's use of information technology such as use of electronic medical records and e-prescribing.

Generally speaking, P4P programs use five types of performance measures:[15]

1. Utilization or cost management (e.g. average emergency visits per patient per year);
2. Clinical quality or effectiveness (e.g. percent of asthmatic patients on controller medications);
3. Patient satisfaction (e.g. percent patients who would recommend the physician to a friend);
4. Administrative (e.g. the practice's use of information technology); and
5. Patient safety (e.g. percent of patients questioned about allergic drug reactions).

Measures Directly Related to Clinical Quality and Effectiveness

Health plans generally have different ways of measuring provider effectiveness and efficiency. The most successful P4P programs typically include three kinds of performance measures:

- **Structural measures**, which gauge the availability of key systems tools and improved care quality;
- **Process measures**, which assess provider performance against evidence-based guidelines and protocols; and
- **Outcome measures**, which are focused on the patient's progress and condition.

The National Committee for Quality Assurance (NCQA) and National Quality Forum (NQF) have developed a detailed provider scorecard based on a variety of health measures[16].

Table 2: Three major types of Performance Measures (Examples)

Structural	Process	Outcomes
• Disease registries • Electronic prescribing • Electronic medical records • Chronic disease management systems	• Preventive screening • Blood pressure (BP) testing • Lipid testing • Smoking cessation advice • Patient education	• Normal weight • Normal BP levels • Normal LDL values • Improved HbA1c levels

*Thomson Medstat, 2005

Pay for Performance Examples

Three models of P4P programs are: the federal Medicare demonstration; the private health plan model; and the private health safety organization.

[15] Endsley, S., Kirkegaard, M., Baker, G., and Murcko, A.C., "Getting rewards for your results: Pay-for-performance programs," Family Practice Management (2005): Online at [www.aafp.fpm].
[16] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, (2004) Online at: [www.medstat.com].

The Pay for Performance Medicare Demonstration Project

In 2003 Medicare and Premier Inc., a nationwide organization for not-for-profit hospitals, rolled out a national, five-year pay for performance demonstration project. In the past, Medicare paid all doctors and hospitals the same rate regardless of the quality of care provided. Spiking costs are requiring physician fees to be cut by 4.3 percent next year and by 26 percent through 2011. This prompted the Bush administration to consider reforms in how doctors are paid. The P4P Medicare project ties payment rates to the quality of care delivered.

The basis for the proposal is a 2003 Medicare test project that tracked hospital compliance with a series of recommended best practices. The study included more than 270 hospitals and found that the median scores for quality improved by roughly 6% in P4P hospitals compared with those not receiving incentives.[17]

The project provides quality bonuses for hospitals based on performance related to treatment in five clinical areas that are critical for Medicare's elderly population: heart attack, heart failure, pneumonia, coronary artery bypass graft surgery, and hip and knee replacements.[18] The performance measures include process and outcome measures.

In Medicare's current demonstration project, about 2 percent of the annual physician payment budget is set aside to reward providers for their performance or participation in quality programs. At the end of the first demonstration year, baselines were set for the bottom 20 percent and the bottom 10 percent. These levels remain static throughout the demonstration project. If any hospitals are below the 10 percent baseline in the third year of the demonstration, they will get a 2 percent reduction in Medicare payments for the clinical area involved, and those between 20 and 10 percent will get a 1 percent reduction. The logic of the demonstration project is to reward doctors who make patients well enough to not need a return visit, and to slow the use of excessive testing.

Some fear that this proposal will hurt some types of physicians who are ineligible to participate in quality programs, because the 2 percent also comes out of their earnings. P4Ps that decrease provider reimbursements to fund incentives have been strongly criticized by provider groups for effectively creating a "dis-incentive" for providers who are already providing quality care.[19] The nature and measurement of quality standards are also a source of contention.

California's PacifiCare: A private health plan example

Some private health plans already utilize P4P designs to inspire their participating doctors to increase the quality and cost efficiency of care. Popular methods generally include defining quality goals and having providers self-report

[17] Mullaney, T.J., and Gleckman, H., "A Big Green Pill for Health Care?" Business Week (June 29, 2005).
[18] Rosenthal, M. B., Fernandopulle, R., Ryu Song, H., & Landon, B., "Paying for Quality: Providers' Incentives for Quality Improvement," Health Affairs 23, No. 2 (2005).
[19] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, (2004) Online at: [www.medstat.com].

their data. Providers then receive bonuses if they meet or exceed goals. A study comparing two large health plans in California - one that implemented a P4P program and one that did not (PacifiCare and Pacific Network respectively) found mixed results.

The groups were each evaluated on improvements for three standards: cervical cancer screening, mammography, and hemoglobin testing for diabetic patients. Only on cervical cancer screenings was PacifiCare's improvement of 6% significantly different from that of Pacific Network. Although the generalizable nature of this study is limited and only covers a narrow range of standards, it represents the potential of success of P4P programs. Incentives have the capacity to gear providers toward completing particular goals.[20]

The Leapfrog Group: Hospital-level model

The Leapfrog Group is the first of its kind: a voluntary program aimed at mobilizing employer purchasing power using measures of provider quality, customer value, and public disclosure. Their "Hospital Rewards Program" provides resources for the measurement and utilization of health standards. They are the first group to give consumers access to data portraying each performer on 30 nationally recognized patient safety practices.

Leapfrog's three main patient-safety practices are: computerized physician order entry for a reduction in errors in prescribing; ICU physician staffing, for employing board-certified critical care specialists; and evidence-based hospital referral, for meeting volume thresholds on six high-risk procedures or for referring patients to hospitals that do.

The criteria used to select these practices are based on whether:

1. Scientific evidence shows that the safety leaps will significantly reduce errors;
2. Implementation by the health industry is feasible;
3. Consumers can readily appreciate their value; and
4. Purchasers or consumers can easily determine which providers meet the standards.

Hospital participation in Leapfrog has increased dramatically and any hospital in the US may participate in their Quality and Safety review. As of October 31, 2005, 1186 hospital surveys have been submitted. This is up 7% from the previous year's total.

In 2004, 85 hospitals in Florida voluntarily completed the Leapfrog online survey. The results can be accessed online at www.leapfrog.org.

Although publicity alone may be incentive for some hospitals to improve, the data collected may be used to test performance levels for incentive programs at any level of medicine. Leapfrog measurements and those like them are often the cornerstone of P4P programs.

[20] M. Rosenthal; R. Frank, Z. Li and A. Epstein., "Early experience with pay-for-performance: From concept to practice." JAMA 294, No. 14 (2005).

For example, in Florida online health care facilities comparison is available through the Agency for Health Care Administration (AHCA). The Agency has an interactive website that lets consumers compare performance measures for Florida's hospitals and ambulatory, or outpatient, surgery centers. The website displays the number of patients, charges, and length of stay, readmission and mortality rates, and complication rates for various medical conditions and procedures in Florida's short term acute care hospitals. This information can be accessed online at www.floridacomparecare.gov.

Challenges to Pay for Performance programs

Although the health plan and hospital P4P programs have demonstrated positive results in improving the quality of health care, many warn against viewing P4P initiatives as a cure-all. The design of incentives is critical in determining whether programs succeed. Some well-intended incentives can spur completely counter-intended results. Standards may cause providers to behave in ways directly opposed to larger patient safety outcomes. The primary concerns or criticisms of P4P programs include:

- **Problems with standardization and transparency of quality measures**

The lack of standardization of measures may be the biggest obstacle for P4P programs,[21] especially as the number of such programs rapidly grows. Not all entities adopt the same indicators of quality even when they evaluate outcomes or practices toward the same disease. One study found as many as ten different performance measurements for diabetes alone, across various P4P programs. Additionally, doctors have expressed concern that there is little transparency in the methodology of quality rankings.

Measures of quality can be "too standardized." If all doctors are rated on the same criteria, the measures may be biased toward some types of physicians or some types of practices. Hospital administrators are especially sensitive to this concern, fearing physicians will send them to the "CEO graveyard" if standards are too rigid and don't consider constraints such as practice size and scope.[22]

It is also feared that P4P incentives will create a "top down" or "cookbook" approach to medicine that undermines professional standards of care. Close adherence to achieving inappropriate standards could retard medical innovation or weaken the doctor's professional autonomy.

- **Problems with quality-based measures**

Tiered P4P programs that rank physicians based on quality have received the most criticism. When the doctor's fees depend on outcomes, the doctor may be punished if a patient does not do well. In many cases patient outcomes do not depend just on the

[21] Darves, B., "Pay-for-performance has quality-improvement potential," Medscape Medical News. (October 2003). Online at: [www.medscape.com/viewarticle/513917].
[22] Devers, K.J., and Liu, G., "Leapfrog patient safety standards are a stretch for most hospitals," Center for Studying Health System Change 77 (February 2004).

doctor's effort or the doctor's quality level, but on a number of other random[23] or even on systematic effects that are beyond a doctor's control.

The most cited consequence of quality-based measures is that P4P programs have the potential to hurt practitioners who serve patients with lower socioeconomic status. This population typically has less successful outcomes and lower patient compliance. Quality-based measures could cause doctors to turn away patients who are poor or ill.

For doctors treating well-to-do patients, quality-based measures may also fail to produce intended results. Here, the incentives offered by the P4P program may not be strong enough to make efforts worthwhile. Especially if quality is measured on the basis of improvement, doctors who already are well-performing may gain little from participation.

In other words, when quality is measured based on health outcomes, doctors can be punished for serving lower-income and medically needy patients, and when quality is measured based on improvement, other doctors may lack an incentive to participate at all.

- **Incentives for cost-savings that may inspire practitioners to limit services**

Another concern regards payment incentives based on cost savings. For example, rewarding doctors for having fewer repeat visits per patient could encourage health care practitioners to limit access to care in order to increase their own salary. Cost savings incentives work best when they are paired with strong, tested measures of health care quality and medical best practices.[24]

- **The burden of data collection**

For small practices and doctors serving needy patients, the costs of implementing reforms may be prohibitive. Purchasing information technology and hiring staff to record patient data and outcomes is costly.[25] This barrier relates to more affluent physicians as well. It is commonly stated that providers require incentives to boost finances by at least 5% in order to effectively engineer behavior.[26] For some providers, the entire incentive bonus may be spent in the process of collecting and reporting data.

Conclusions

Great care is required so that incentives do not punish providers for factors beyond their control, or inspire them to turn away clients based on demographic characteristics. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Institute of Medicine (IOM), American Medical Association (AMA), and many other national organizations are emphasizing that P4P programs must be designed well to work.

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[23] Fine, A. "Quality Care and Best Practices," Managed Care Quarterly 13, No. 3, (2005): 11-12.
[24] Betbeze, P., "Pay for Performance Tipping Point," Health Leaders, (September, 2005).
[25] Rosenthal, M.B., Frank, R.G., Li, Z., and Epstein, A., "Early experience with pay-for-performance: From concept to practice." JAMA 294, No. 14 (October 12, 2004): 1788-1793.
[26] Nozar, R., "Medicare mulls incentive program: P4P may penalize non-participants, while others receive higher payments," Ophthalmology Times, 30, No. 5. (March 1, 2005).

To facilitate this process, organizations are developing standards to evaluate P4P programs. The American Medical Association (AMA) has extensive guidelines for its members. The guidelines contain about 50 detailed conditions in five general categories including: patient-physician relationships; physician participation; and incentives. According to the AMA, P4P programs must be designed to:

- Ensure quality of care;
- Foster the relationship between patient and physician;
- Offer voluntary physician participation;
- Use accurate data and fair reporting; and
- Provide fair and equitable program incentives.[27]

Dr. Mary Frank, President of the American Academy of Family Physicians recommends that P4P programs provide incremental incentives so that "doctors do not have to go from 1 to 100 before earning rewards."[28]

Overcoming the main challenges for P4P

In summary, to ensure effective P4P programs, efforts need to be made to:

- Standardize measures so that fair comparisons are made between providers;
- But not standardize them too much, so that doctors may still have professional autonomy and make individualized decisions for patients;

- Inspire physicians to make cost savings and not provide unnecessary care;
- But not inspire cost-savings to the point that doctors will turn patients away and limit services for those in need, in order to gain personal reward;

- Reward high performance and quality;
- But ensure that those doctors serving poor or ill patients are not unfairly punished

- Reward improvements in quality;
- But ensure that already well-performing doctors still have cause to participate;

- Reward and encourage the use of information technology;
- But take into consideration that these are costly improvements, and therefore, provide reasonable financial incentive for their use.

Staff Recommends

Incentives are going to continue to permeate the health care market. It is likely that over time the health care industry will develop more uniform P4P standards with transparent quality indicators. If this does not develop it may become necessary for the Florida legislature to provide regulatory standards for P4P programs.

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[27] "American Medical Association Principles and Guidelines for PFP," American Medical Association, (June 2005).
[28] Darves, B., "Pay-for-performance has quality-improvement potential, AAFP says."Medscape Medical News. (October 2003). Online at [www.medscape.com/viewarticle/513917].

The Legislature should amend the Florida Patient Safety Corporation (FPSC) enabling legislation to remove barriers to productivity within the corporation. The advisory committee structure should be streamlined to allow the board more freedom to appoint members. Further, the long list of the duties assigned to the board should be limited to those duties that are not already the responsibility of other state organizations (e.g., electronic medical records).